								1
IPDR6702 RUN DATE:	03/19/2006		TPI	NORTH CAROLINA RS CHECKWRITE SUMMARY REPORT	1	PAG	E: 1	
				CHECKWRITE DATE: 03/21/2006				
				FINANCIAL PAYER: NCDMH				
		-						TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404901		8505	13	CLAIM DENIED DUE TO INSUFFICIE				
3404901	SMOKY MOUNTAINM H/DD/SAS	8505	3	NT BUDGET				
	H/DD/SAS	<del> </del>	-					
	<u> </u>	0	0		0	3	3	
		-			-			
3404904	WESTERN HIGHLAN	11	127	CLIENT NOT ELIGIBLE ON SERVICE				<u> </u>
	DS LME			DATE				
		-	-					<u> </u>
		191	31	CLIENT ID NUMBER DOES NOT MATC	-	207	5821	5614
		†	†	H PATIENT NAME	1	201		3014
		8000	22	NO RATE AVAILABLE ON FILE TO P				<u> </u>
		1	<del> </del>	RICE THIS CLAIM DETAIL	1		-	
		† · · · · · · · · · · · · · · · · · · ·	<del> </del>					<u> </u>
2404017		8505	775					
3404910	PATHWAYS	8505	775	CLAIM DENIED DUE TO INSUFFICIE	-		<del> </del>	
	<del>                                     </del>	<del> </del>	<del> </del>		+		<del> </del>	<del>                                     </del>
		· · · · · · · · · · · · · · · · · · ·	· · · · · · ·					
		21	193	DUPLICATE OF CLAIM-SYSTEM	1	1584	4451	2867
	<del> </del>	<del> </del>			<del> </del>		<b> </b>	
		-	1					
		11	152	CLIENT NOT ELIGIBLE ON SERVICE				
		ļ	ļ	DATE				
	ļ	ļ	<del> </del>				ļ	
3404912	CATAWBA COUNTYM	8505	1799	CLAIM DENIED DUE TO INSUFFICIE				
	ENTAL HEALT			NT BUDGET				
		ļ					ļ	
		8800	84	FURTHER PROCESSING NECESSARY,	16	1919	2388	469
		<u> </u>	<u> </u>	PLEASE CHECK FOR CLAIM ON	- 10	1313	2300	40.
				FUTURE RA'S.				
		111	10	CLIENT NOT ELIGIBLE ON SERVICE				
		11	10	DATE	-		-	<u> </u>
3404913		8599	39	DETAIL NOT COVERED BY COMBINAT				
3404913	MECKLENBURG COM	8599	39	ION OF RECIPIENT, PROVIDER AND				
	ENTAL HEALT	<del> </del>	<del> </del>	BENEFIT PACKAGE.	-		-	<u> </u>
		8952	13	CLAIM DENIED DUE TO AGE RESTRI CTIONS FOR TARGET POPULATION	0	55	127	72
		ļ	ļ	CTIONS FOR TARGET POPULATION			ļ	-
	1	<del> </del>	<del> </del>					<u> </u>
		11	2	CLIENT NOT ELIGIBLE ON SERVICE				
		ļ		DATE				
		<del> </del>	<del> </del>	<u> </u>			<del> </del>	
3404916	CROSSROADS BEHA	24	14	PROCEDURE CODE, PROCEDURE/MODI	1		<b></b>	
	VIORAL HEAL	1:		FIER COMBINATION OR PROCEDURE				
				CODE/TYPE OF SERVICE COMBINATI				
		0	0		- 0	14	14	-
	1	t	† · · · · ·	†	1	14	14	<b>—</b>
		1			1			
3404917	CENTERPOINT HUM	8505	763	CLAIM DENIED DUE TO INSUFFICIE				
l	AN SERVICES	<del> </del>	ļ		-		-	
		1	†					<b>—</b>
		8518	43	CLAIM DENIED, SUBMITTED BEYOND	24	867	897	30
		ļ	ļ	FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	1		ļ	ļ
	<del>                                     </del>	<del> </del>	<u> </u>		+		<b> </b>	<del>                                     </del>
		8622	27	60 RESIDENTIAL LEVEL II TREATM				<b></b>
				ENT RECEIVED, PA IS REQUIRED				
		ļ		FOR ADDITIONAL SERVICE.			ļ	ļ
3404918	ROCKINGHAM CO M	0	0	*** NO DATA TO REPORT ***	+			
	ROCKINGHAM CO M	t	<u> </u>	1	1		l	<b></b>
		1						
		0	0			0	0	

		UZOU DENIZAZ	I I I I I I I I I I I I I I I I I I I				TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404919	GUILFORD CO MEN	8505	2172	CLAIM DENIED DUE TO INSUFFICIE  NT BUDGET				
	TAL HEALTHC	ļ		NT BUDGET				
		8599	94	DETAIL NOT COVERED BY COMBINAT	39	2439	7320	3392
				ION OF RECIPIENT, PROVIDER AND	39	2439	/320	3394
		+	-	BENEFIT PACKAGE.				-
		+						
		11	49	CLIENT NOT ELIGIBLE ON SERVICE	-			
		1		DATE				
		+	-					
		1						
3404920	ALAMANCE CASWEL	8518	538	CLAIM DENIED, SUBMITTED BEYOND				
	L AREA MH D	†		FILING TIMELIMIT. PRIOR				
		1		FISCAL YEAR DOS (JULY 1 - JUNE			i	
		1						
		8599	97	DETAIL NOT COVERED BY COMBINAT	32	923	5074	4151
		1		ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		79	86	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
3404921	ORANGE PERSON C	8505	429	CLAIM DENIED DUE TO INSUFFICIE				
	HATHAM AREA			NT BUDGET				
		8599	83	DETAIL NOT COVERED BY COMBINAT	8	674	3706	3032
		1		ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		J					L	
		8000	55	NO RATE AVAILABLE ON FILE TO P				
		ļ		RICE THIS CLAIM DETAIL				
		J						
3404922	THE DURHAM CENT	8599	251	DETAIL NOT COVERED BY COMBINAT				
	ER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8518	179	CLAIM DENIED, SUBMITTED BEYOND				
		8518	179		31	575	774	199
				FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8505						
		8505	34	CLAIM DENIED DUE TO INSUFFICIE			L	<u> </u>
		ļ		NT BUDGET				
		ļ					ļ	
3404923		111	145	CLIENT NOT ELIGIBLE ON SERVICE				
3404923	FIVE COUNTY MH	11	145	DATE				
		ļ		DATE				
		-						
		8599	57	DETAIL NOT COVERED BY COMBINAT				
		0333	37	ION OF RECIPIENT, PROVIDER AND	0	307	5412	5105
		<del> </del>		BENEFIT PACKAGE.	ļ			
	+	+	-				<del> </del>	
		8518	35	CLAIM DENIED, SUBMITTED BEYOND			<b> </b>	
	1	1	-	FILING TIMELIMIT. PRIOR	-		l	+
	1	+	-	FISCAL YEAR DOS (JULY 1 - JUNE	-		-	
	+	+	<del> </del>	1	<del> </del>		<b> </b>	<del>                                     </del>
3404925	SANDHILLS CENTE	8505	2885	CLAIM DENIED DUE TO INSUFFICIE	<b></b>		<b></b>	
	R FOR MH/DD	+	<del> </del>	NT BUDGET	-		<b> </b>	
		1	-					
	1	1						
		8599	236	DETAIL NOT COVERED BY COMBINAT	0	3808	8478	4670
	1	1		ION OF RECIPIENT, PROVIDER AND		3300	, , , , , , , , , , , , , , , , , , ,	4070
		1		BENEFIT PACKAGE.				<b></b>
		1						
		8800	157	FURTHER PROCESSING NECESSARY,				
		1		PLEASE CHECK FOR CLAIM ON				<b>T</b>
		1		FUTURE RA'S.				
		1						T
3404926	SOUTHEASTERN RE	11	251	CLIENT NOT ELIGIBLE ON SERVICE				
	G MENTAL HL	1		DATE				<b></b>
	1	1	1					
		1						
		8599	94	DETAIL NOT COVERED BY COMBINAT	n	397	2619	2222
	<u> </u>	1		ION OF RECIPIENT, PROVIDER AND	· · · · · ·	357	1 2017	
		1		BENEFIT PACKAGE.				T
		1						T
		8533	39	SERVICE FACILITY LOCATION CANN				
		1		OT BE AN ATTENDING PROVIDER				<b>T</b>
		1		IDENTIFIED AS AN INDIVIDUAL.				
		+		+				+

PROVIDER		HIGH DENIAL	NUMBER OF				TOTAL	TOTAL
PROVIDER NUMBER	DRAWTER NAME	HIGH DENIAL EOBS	DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
	PROVIDER NAME	t			DENIALS	DENIALS	FINALIZED	PAID
3404927	CUMBERLAND CO M	8505	149	CLAIM DENIED DUE TO INSUFFICIE				
	HC	ļ	ļ	NT BUDGET			ļ	
		-					-	
		8622	83	60 RESIDENTIAL LEVEL II TREATM	21	445	1158	713
				ENT RECEIVED, PA IS REQUIRED				
		ļ	ļ	FOR ADDITIONAL SERVICE.			L	
		8000	79	NO RATE AVAILABLE ON FILE TO P				
				RICE THIS CLAIM DETAIL				
		†					l	
3404929	LEE HARNETT MH/	0	0	*** NO DATA TO REPORT ***				
	DD/SAS	1					-	
		<u> </u>						
		0	0			0		0
		ļ						
3404930	JOHNSTON COUNTY	8599	155	DETAIL NOT COVERED BY COMBINAT				
	MNTL HLTHC			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8621	25	60 RESIDENTIAL LEVEL III TREAT				
		0021	23	MENT RECEIVED, PA IS REQUIRED	1	182	1220	1038
	1	t	<del>                                     </del>	FOR ADDITIONAL SERVICE.	<u> </u>		<del>                                     </del>	
		8935	1	ASTNC INELIGIBLE TO RECEIVE SE				
	-	<del> </del>	-	RVICES IN IPRS.	-			
	1	<del>                                     </del>			-		<b></b>	
3404931	WAKE CO HUM SVC	27	24	DIAGNOSIS CODE MISSING OR INVA				
	BILLING OF			LID. VERIFY AND ENTER THE				
		ļ		CORRECT DIAGNOSIS CODE AND SUB				
	-	5308	23	PRIOR AUTHORIZED UNITS EXCEEDE		111	1097	986
				D		111	1097	300
		8599	12	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
		-		BENEFIT PACKAGE.			-	-
		†						
3404933	SOUTHEASTERN CT	8599	115	DETAIL NOT COVERED BY COMBINAT				
	R FOR MH/DD	<del> </del>	ļ	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			ļ	
		ł		BENEFII PACKAGE.				
		79	77	THIS SERVICE IS NOT PAYABLE TO	37	293	1243	950
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8000	30	NO RATE AVAILABLE ON FILE TO P			ļ	
		0000	30	RICE THIS CLAIM DETAIL			<del> </del>	
3404934	ONSLOW CARTERET	8000	182	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL				
	BEHAV HEAL	+		RICE THIS CLAIM DETAIL	-			
		10	161	DIAGNOSIS OR SERVICE INVALID F	42	941	2421	1480
				OR CLIENT AGE. VERIFY CID,				
	<del> </del>	<del> </del>		DIAGNOSIS, PROCEDURE CODE FOR			ļ	
	1	8599	140	DETAIL NOT COVERED BY COMBINAT	-		<b> </b>	<del> </del>
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404935	COLUMN CO. LEGISTRA	10	10	*** NO DATA TO REPORT ***	-			
- 104333	WAYNE CO MENTAL HEALTH CTR	f	-		-		l	
		0	0			0		0
		<del> </del>					<del> </del>	
3404936	WILSON-GREENE M	8505	168	CLAIM DENIED DUE TO INSUFFICIE	1		l	
	ENTAL HEALT			NT BUDGET				
		ļ. — — — — — — — — — — — — — — — — — — —						
		8599	140	DETAIL NOT COVERED BY COMBINAT	-		ļ	<del></del>
		† · · · ·		ION OF RECIPIENT, PROVIDER AND	3	317	1358	1041
		1	<del>                                     </del>	BENEFIT PACKAGE.				
		8931	3	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
	1	<del> </del>		IN IERO.			<del> </del>	
	1	t	<del> </del>	i	1		<del>                                     </del>	
3404937	EDGECOMBE NASH	21	12	DUPLICATE OF CLAIM-SYSTEM				
	MNTL HLTH C							
		ļ					ļ	<u> </u>
	+	191	4	CLIENT ID NUMBER DOES NOT MATC	0	20	1399	1379
		t	-	H PATIENT NAME	1	20	1399	13/9
		1						
		1	Γ΄				Γ	
					+			
		11	3	CLIENT NOT ELIGIBLE ON SERVICE				
		11	3	CLIENT NOT ELIGIBLE ON SERVICE DATE				

								moma r
PROVIDER	<del>                                     </del>	HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
	THOVEDER MAIN	1			DIMINIDO	DENTIFIED	110001000	INID
3404938	VGFW DBA RIVERS	0	0	*** NO DATA TO REPORT ***				
	TONE COUNSE							
			<u> </u>				i	
		0	0		0	0		0
			· · · · · · · · · · · · · · · · · · ·				<del>                                     </del>	
3404939	NEUSE MENTAL HE	8599	72	DETAIL NOT COVERED BY COMBINAT				
	ALTH CENTER	<u> </u>		ION OF RECIPIENT, PROVIDER AND				<del>                                     </del>
			<u> </u>	BENEFIT PACKAGE.				
		8505	47	CLAIM DENIED DUE TO INSUFFICIE	0	126	545	419
				NT BUDGET				
		10	6	DIAGNOSIS OR SERVICE INVALID F				
				OR CLIENT AGE. VERIFY CID,				
				DIAGNOSIS, PROCEDURE CODE FOR				
		1					i	
3404941	PITT CO MH/DD/S	8535	1206	SERVICE FACILITY LOCATION WAS				
	AS CENTER			NOT INCLUDED IN YOUR 837.				
			<u> </u>	PLEASE RESUBMIT YOUR CLAIM WIT			<del>                                     </del>	
	1	1			1			
	1	8599	1007	DETAIL NOT COVERED BY COMBINAT	14	3670	8109	4439
l		1		ION OF RECIPIENT, PROVIDER AND	1	3070	010.	
				BENEFIT PACKAGE.				†
	1	1		†	1		· · · · · ·	
l		4102	620	YOU ARE ATTEMPTING TO ADJUST A	1			<b>†</b>
			<del></del>	CLAIM THAT IS EITHER NOT			<del> </del>	
		-		FOUND ON OUR FILE OR IS NOT FO				
			+		-		-	
3404942	ROANOKE CHOWANH	21	37	DUPLICATE OF CLAIM-SYSTEM	-			<del></del>
	UMAN SERVIC				-			<u> </u>
	UMAN SERVIC			+				<del>                                     </del>
				-				-
		11	32	CLIENT NOT ELIGIBLE ON SERVICE	-	121	572	451
		1		DATE	9	121	5/2	401
	<del> </del>	+		+			<del> </del>	
		8599	27	DETAIL NOT COVERED BY COMBINAT				<u> </u>
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404943	ALBEMARLE MENTA	79	59	THIS SERVICE IS NOT PAYABLE TO				
3404343		173	133	YOUR SUBMITTED BILLING			-	-
	L HEALTH CE			PROVIDER TYPE AND SPECIALTY IN				
		+		PROVIDER TIPE AND SPECIALITY IN				
		8931	31	AMTNC INELIGIBLE TO RECEIVE SE				
		0331	31	RVICES IN IPRS.	47	209	1493	1284
				RVICES IN IPRO.				
								<u> </u>
		5404	29	SEVERE DUPLICATE: SAME ATTO PR				<del></del>
	1	3404	4.7	SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD	1		-	
<u> </u>				OV/FCODE/TOS/DOS/MOD	+			<del></del>
L			-				<u> </u>	
3404944		21	71	DUPLICATE OF CLAIM-SYSTEM	1		-	
2404344	EASTPOINTE HUMA	121	7.1	DOTLICALE OF CLAIM-SISTEM	-		-	
	N SERVICES				1			-
		-			+		-	
		0.621	27	CO DECEMBERT TRUET TIT MORAM			L	
		8621	21	60 RESIDENTIAL LEVEL III TREAT	9	188	1542	1354
		-		MENT RECEIVED, PA IS REQUIRED  FOR ADDITIONAL SERVICE.	+		<del></del>	
		-		FOR ADDITIONAL SERVICE.	1	ļ		
	<del> </del>	1,000	100	DETAIL NOT COVERED BY COMBINAT			<u> </u>	ļ
		8599	26	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND			-	ļ
		-		ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			ļ	
	<u> </u>			BENEFIT FACKAGE.			<u> </u>	<u> </u>
		4						
3404946	FOOTHILLS AREAM	11	407	CLIENT NOT ELIGIBLE ON SERVICE	1			<u> </u>
	ENTAL HEALT	-		DATE				
	1	1			1			
					1			
		8000	236	NO RATE AVAILABLE ON FILE TO P	35	1141	3587	2446
				RICE THIS CLAIM DETAIL				
		8599	145	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
		ļ	ļ				ļ	
3404957	TIDELAND MENTAL	8599	160	DETAIL NOT COVERED BY COMBINAT				
	HEALTH CTR	1	1	ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8000	43	NO RATE AVAILABLE ON FILE TO P	1	1 247	459	0 4343
	<del>                                     </del>	<u> </u>		RICE THIS CLAIM DETAIL			1 133	4545
		79	14	THIS SERVICE IS NOT PAYABLE TO			-	
		1	1	YOUR SUBMITTED BILLING	1		<u> </u>	
				PROVIDER TYPE AND SPECIALTY IN				
3404979	NEW RIVER AREAM	8505	199	CLAIM DENIED DUE TO INSUFFICIE	ļ	<del>                                     </del>		
	H/DD/SA PRO			NT BUDGET				
		-	-					
		8000	160	NO RATE AVAILABLE ON FILE TO P	7	7 663	485	8 4195
				RICE THIS CLAIM DETAIL				
		-			-			
	<del> </del>	8599	82	DETAIL NOT COVERED BY COMBINAT	<del> </del>	<del>                                     </del>	<b></b>	
				ION OF RECIPIENT, PROVIDER AND				
			T	BENEFIT PACKAGE.				